NH Department of Health and Human Services

Update on Care Management

Nick Toumpas

January 24, 2013

Agenda

- Overview of Medicaid
  - Why we must change the business model
- Overview of Care Management initiative
  - Contracts timeline
  - Implementation timeline and challenges
- Current Status
- Q&A

Medicaid in New Hampshire

- Spends approximately $1.3B and is 2nd largest program in State of NH budget
  - About $1B in provider payments
  - Largest segments include
    - Medical and Rx services
    - Behavioral health services
    - Long-term care services and supports
  - Serves approximately 10% of population
    - Significant regional variances in SFY 10
      - From 6% in Derry to 17% in Lancaster
  - Payment strategy is primarily "fee for service"
  - Through ~10,000 enrolled providers

Spending by Eligibility Category_Medicaid

	% Enrolled	Spend	%
Low Income Child	58.0%	$ 224,341,503	22.1%
Low Income Adult	15.8%	$ 81,500,086	8.0%
Severely Disabled Child	1.1%	$ 37,997,947	3.7%
Disabled Physical	6.4%	$ 201,241,500	19.8%
Disabled Mental	8.1%	$ 219,639,929	21.6%
Elderly	7.1%	$ 246,343,546	24.2%
QMB/SLMB	6.8%	$ 5,512,028	0.5%

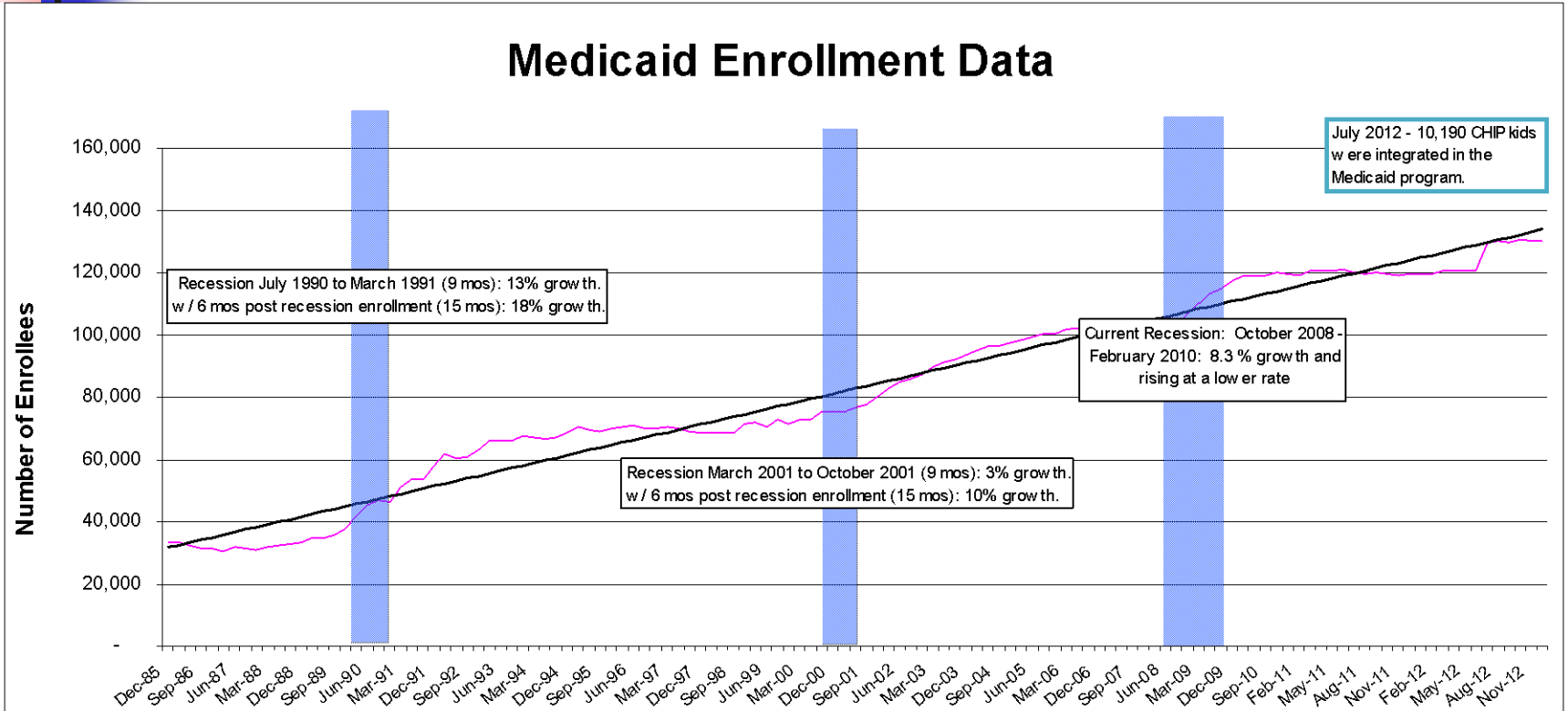
~74% of members/ ~30% of costs

~22% of members/ ~66% of costs

QMB: Qualified Medicare Beneficiary/SLMB: Special Low Income Beneficiary

Total SFY PP of $1,016,78,930 for services 7/1/09-6/30/10

Medicaid Caseload Trend



NOTES: Dec. 1985 to June 2000, Data provided by DFA caseload with an average of 1.53 enrollees per a case. Data source for Sept. 2000 to Nov.2012, enrollment data is from DHHS ORA Rock Enrollment Report.

* Recession Periods - July 1990 to March 1991; March 2001 to October 2001 and October 2008 to February 2010.

Beginning in July 2012, 10,190 CHIP kids were integrated in the Medicaid program.

Why must we change?

- Current Medicaid system is unsustainable
  - Rising costs due to growth and aging of NH's population
  - Many with more complex needs
  - Resource constraints at the State and Federal level
- Current system is "transactional" from both a financial and service delivery basis
  - System does not promote efficiency and coordination

What is Care Management?

- Care management, or Managed Care is:
  - Approach to pay for and delivering health care
  - Provides coordinated services to enrollees through a network of providers
  - Manages appropriate and effective health care services

Care Management

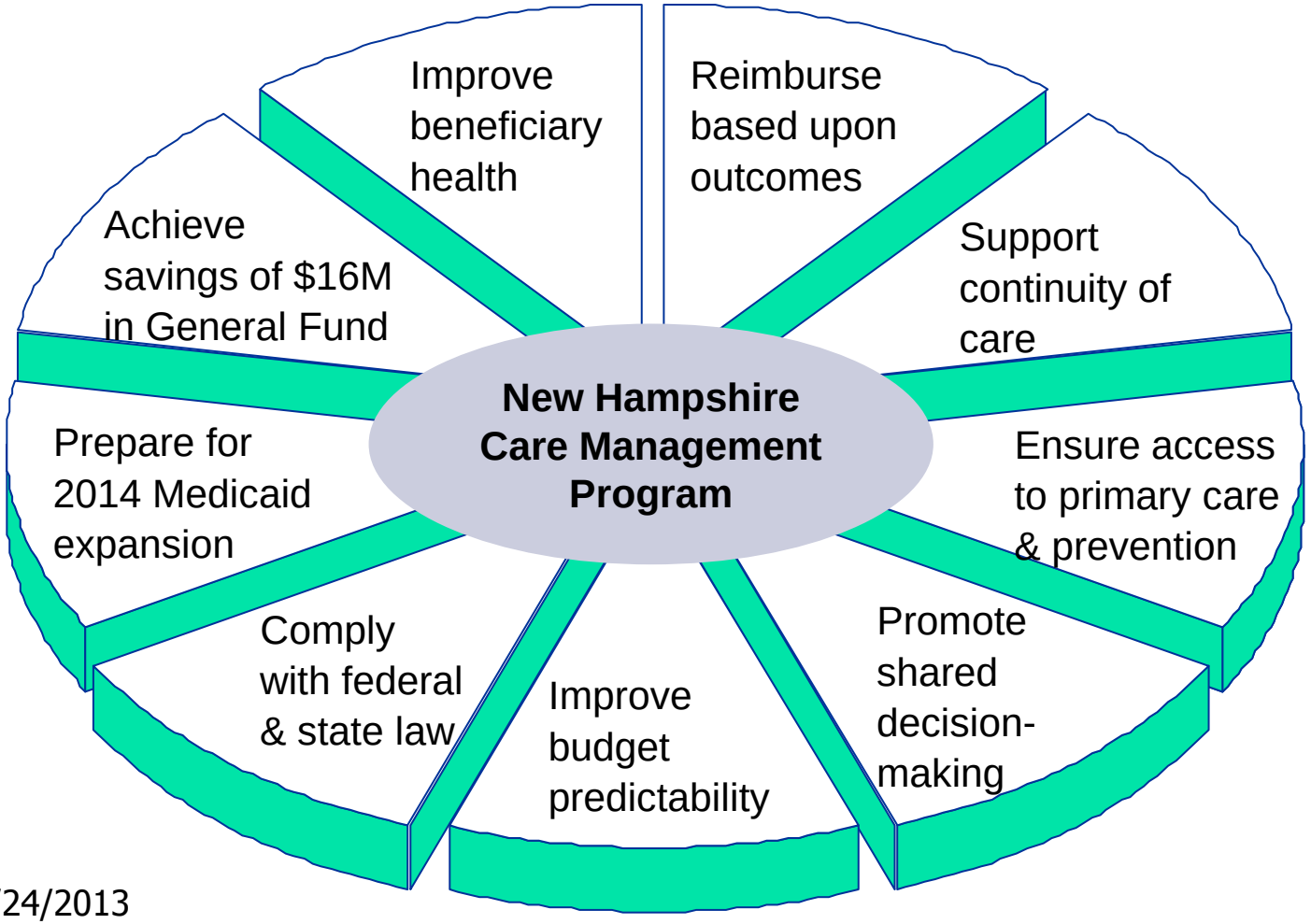
Goals

Design

Contract

Status

Program Goals



Program Design

- The Care Management program will be implemented via a three-step approach
  - Step 1: All populations, including "duals", foster children and Home Care for Children with Severe Disabilities on an optional basis, waiver and nursing home services remain in fee-for-service
    - Target date was July 1, 2012---TBD
  - Step 2: All populations mandatory, waiver and nursing home services added
    - Target date is one-year after go-live of Step 1
  - Step 3: Assuming Medicaid Expansion is enacted in NH
    - Effective date is January 1, 2014

Program Design Features

- Care coordination
  - Primary care, specialty care, transportation and other covered services
- Patient Centered Medical Home Support
- Chronic Disease Management
- Special Needs Program
  - For high cost/high risk members with complex issues
- Wellness and Prevention Programs
- Quality Assessment and Performance Improvement Program
- Quality Incentives
- Payment Reform

Managed Care
How do we increase efficiency?

- SFY 12/13 budgeted savings projection of $16M GF
  - Focus on **improving health**, not just health care
  - Increase timely access to **primary care**
  - Implement **single point of accountability** for care coordination
  - Better **manage transitions** between sites of care
  - **Reduce avoidable hospital admissions and readmissions**
  - **Reduce emergency department** use for primary care
  - Improve compliance with recommended care
  - **Reduce duplication of tests**
  - Greater integration of public health and prevention

Contract

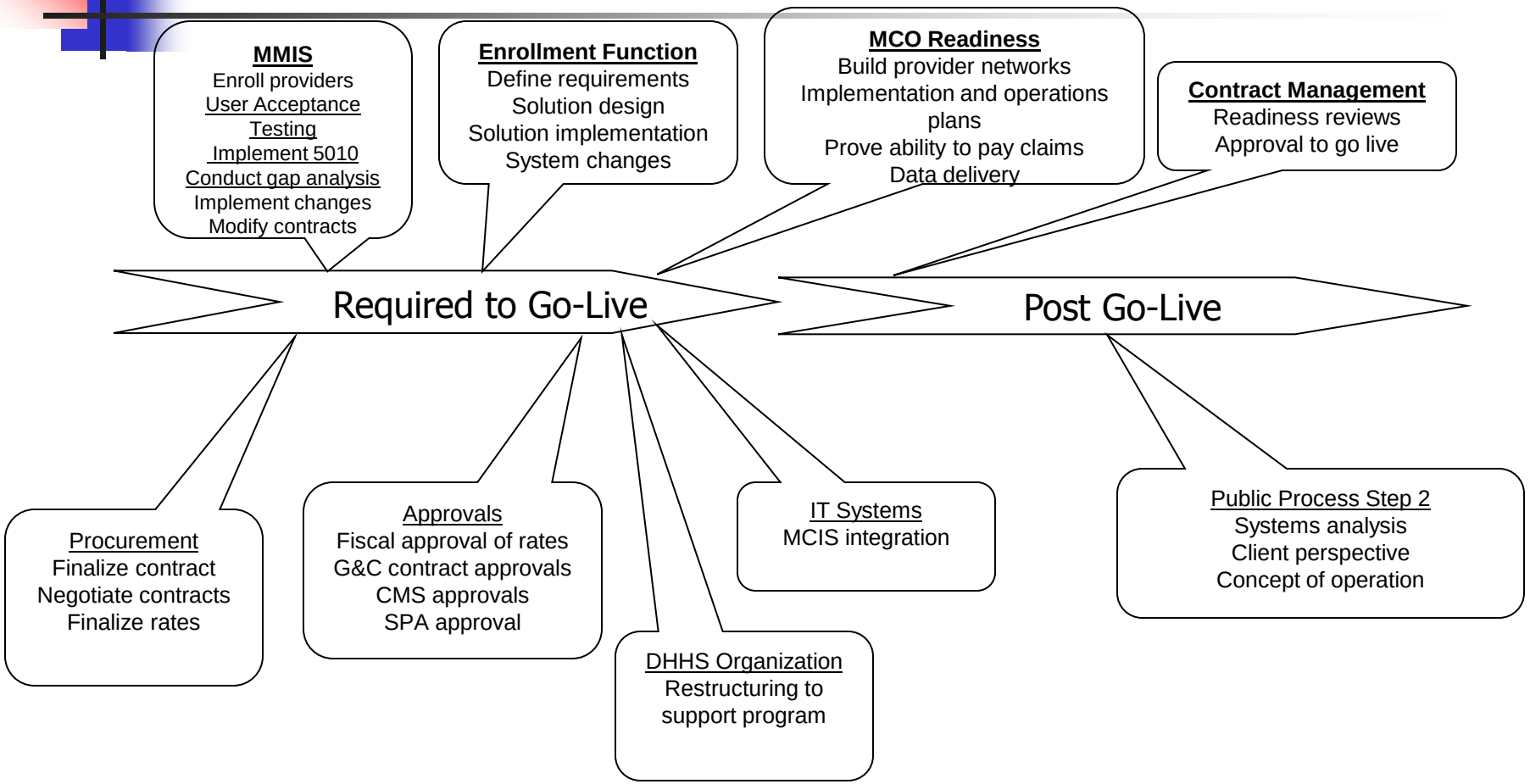
- 3 Managed Care Organizations
  - Centene, Meridian, Well Sense
  - Statewide coverage is required by each
- Approved by G&C in 2012
  - Value of first year $382M
- Rates approved by Fiscal
  - Contracts and rates pending approval by CMS
- One core contract
  - Unique and individual approaches to meeting requirements

Current Status

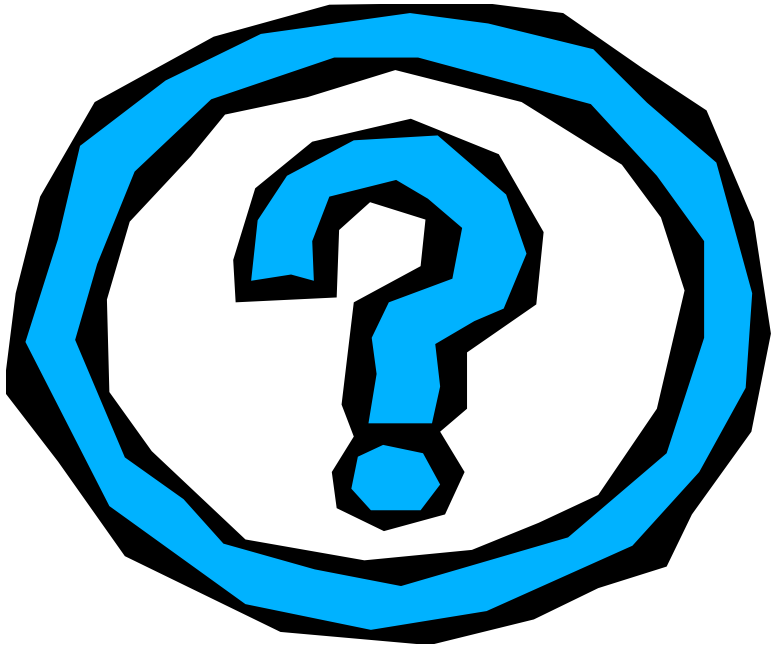
- Program development progressing on multiple levels, but no clear time for implementation
- State
  - 3 Contracts approved
    - Centene, Meridian, Boston Medical
    - Medicaid expansion was mandatory at time of RFP and contract
  - Fiscal Committee approved rate cells
- Federal
  - Issues raised by CMS re: contract terms and rates addressed
  - CMS reviewing network development updates
  - State Plan Amendment has been approved
- DHHS
  - Preparations and readiness for operations and organization
  - Developing rates for Step 1-Year 2 and Step 3
  - Using State Innovation Model initiative with stakeholder engagement to develop design for Step 2
- MCO's
  - Multiple levels of preparation as specified in contract
  - Essential to a go-live is development of an adequate network for services
    - Only a few hospitals have contracts with the MCO's
    - Community Mental Health Centers working rates
    - Impact of uncompensated care in both areas

Targeting July 1, 2012

Tasks Required



Thank You



NToumpas@DHHS.State.NH.US
(O) 603-271-9446, (C) 603-545-4995